STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155656	A. BUILDING 01 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY NURSING AND REHABILITATION CENTER	2827 NORTHGATE BLVD FORT WAYNE, IN 46835

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/24/12 Facility Number: 000275 Provider Number: 155656 AIM Number: 100290930 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Canterbury Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000)	K0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed soley because it is required by the provision of federal and state law.The facility respectifully request that this plan of correction serve as our allegation of compliance effective 6-11-12.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 120 and had a census of 98 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/25/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 medical supply storage rooms with combustibles, measuring over 50 square feet in size, was provided with a self closing device. This deficient practice could affect any resident evacuated from the 100 hall through the 100 to 500 hall exit door. Findings include: Based on observation with the Director of Maintenance on 05/24/12 at 1:20 p.m., the corridor door to the medical supply room with combustible storage, measuring over 50 square feet in size, lacked a self	K0029	1) Correction of alleged deficient practice: The medical supply storage room will have a self-closer door mechanism installed to ensure automatic closing of the door.2) Identification of other potential residents affected: The maintenance department completed a visual audit of all areas throughout the remaining part of the facility for potential identification of other doors that would require automatic closers. No others were identified.3) Systematic Change: The maintenance director will audit all rooms not identified as resident rooms on a monthly basis to ensure there are no rooms being utilized for storage without the automatic door closer. Any areas identified will be corrected.4) Monitoring of System: The administrator will monitor compliance during facility rounds wkly for 4 wks, then monthly for 3 months and then once a quarter	06/11/2012

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	closing device. The supply room contained at least fifty three cardboard boxes of supplies such as Band-Aids, toilet tissue, cups, at least one hundred packages of adult briefs and empty cardboard boxes. Based on an interview with the Director of Maintenance at the time of observation, this was previously a resident room and he confirmed the storage of combustible items. 3.1-19(b)		thereafter until the facililty completes 2 quarters without incidents of non-compliance. Results of the monitoring process will be discussed at CQI monthly meeting for recommendations as needed.	

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K0048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan that included the use of fire extinguishers in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on a record review with the Director of Maintenance and the Administrator on 05/24/12 at 3:00 p.m., the "Emergency	K0048	1) Correction of alleged deficient practice: The facility fire Safety Plan was amended to inculde the types of fire extinguishers utilized throughout the facility including the kitchene k-class fire extinguisher.2) Identification of others that have potential to be affected: The facility fire safety plan was reviewed to ensure that it meets the requirements for a written health care occupancy fire safety plan under LSC 19.7.2.2. The policy is current.3) System change: All staff inserviced to the amended policy regarding the facility's fire safety plan. New employees will receive training during orientations and monthly fire drills by the maintenance director.4) Monitoring: The fire safety plan will be reviewed quarterly during the CQI meeting to identify and upchanges to ensure that the facility's plan is kept.current with life safety code.	06/11/2012

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	Preparedness Manual" did not address the types of fire extinguishers through out the facility including the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. Based on an interview with the Administrator at the time of record review, she stated the Corporation office did not have this documentation. 3.1-19(b)			

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K0064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 2 fire extinguishers in the 300 hall was provided maintenance when the gauge on the fire extinguisher indicated it needed recharging. NFPA 10, Standard for Portable Fire Extinguishers, in Section 4-4.1 requires fire extinguishers to be subjected to maintenance no more than one year apart or when specifically indicated by inspection. This deficient practice could affect any of the 16 residents on 300 hall. Findings include: Based on an observation with the Director of Maintenance on 05/24/12 at 12:18 p.m., the gauge on the portable fire extinguisher located on the 300 hall near resident room 303 indicated the fire extinguisher needed to be recharged. This was acknowledged by the Director of Maintenance at the time of	K0064	1) Corrective Action taken for alleged deficient practice: The fire extinguisher on 300 hall was serviced and charged on 5-25-12.2) Identification of others with potential to be affected:Remaining fire extinguishers throughout the building were checked by the maintenance director for service needs and/or charge. There were no other extinguishers identified that required charging.3)Systematic change: Fire extinquishers will be checked wkly for charge levels by the maintenance director during facililty rounds. Any identified areas will be corrected.4) Monitoring of system: The administrator will monitor routine fire extinquishers wkly for compliance during wkly rounds and will document findings in the preventative maintenance logs. Audit results will be reviewed with the CQI meeting monthly for 3 months. any identified non-compliance will be addressed for further recommendations.	05/25/2012

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	observation. 3.1-19(b)			

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K0066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure 2 of 5 self closing metal containers in the staff smoking areas were used only to empty ashtrays. This deficient practice could affect any staff in the staff smoke area. Findings include: Based on an observation with the Director of Maintenance on	K0066	1) Corrective action for alleged deficient practice: The trash cans identified were removed from smoking area and discarded.2) Identification of others that have potential to be affected: All smoking containers currently in use were assessed by the maintenance director to ensure they are free from combustibe trash. 3) Systematic change: Smoking containers will be checked dly by the maintenance director to ensure that they are free from combustible trash. Signs have been placed on smoking containers to alert staff	06/11/2012

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	05/24/12 at 12:15 p.m., the metal receptacle under the metal ashtray and another metal trash can contained a mixture of cigarettes butts and combustible trash. This was acknowledged by the Director of Maintenance at the time of observation. 3.1-19(b)		and/or visitors to use only for cigarette butts.4.Monitoring of system change: The administrator will monitor wkly for compliance during facility rounds. Any issues identified will be corrected. Round results will be reviewed monthly in the CQI meeting until the facility has submitted 3 reviews with no compliance issues.	

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K0076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 1. Based on observation and interview, the facility failed to ensure 1 of 2 liquid oxygen storage rooms was separated by construction with a one hour fire resistant rating. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.2. NFPA 99, 4-3.1.1.2(a)requires at least one hour fire resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. This deficient practice could affect any of the twelve residents in the 100 hall. Findings include: Based on an observation with the Director of Maintenance on 05/24/12 at 1:10 p.m., a stationary liquid oxygen unit was	K0076	1) Corrective Action for alleged deficient practice: The stationary liquid oxygen unit was removed from resident room 102.2) Identification of others with potential to be affected: All resident rooms were checked by the maintenance director to ensure no other liquid oxygen units were stored in areas without 1 hr fire resistant rating.3) Systematic Change: Nursing will be required to remove liquid oxygen units from a resident room upon time of discharge from the facility. Nursing staff inserviced to system change.4)Monitoring of System: The maintenance director will monitor resident rooms daily for any liquid oxygen units being stored in resident rooms during his daily rounds. The administrator will monitor wkly during facility rounds for non-compliance issues. Any issues identified will be corrected. Round results will be reviewed monthly during CQI and	06/11/2012

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	observed in resident room 102. No resident was in the room at this time. Based on an interview with the RN Supervisor at the time of observation, she stated the resident was taken to the hospital on Saturday May 19. The facility was under the impression the resident would be returning the next day. To date the resident has not returned and the facility learned this morning she may not be returning. The RN Supervisor stated she was hesitant about storing the liquid oxygen unit in the oxygen storage room for fear it might be used and this resident requires an extreme amount of oxygen. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 oxygen cylinders in the 400 hall oxygen storage room was properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b) 27 which requires freestanding cylinders to be chained or supported in a cylinder		any issues of non-compliance will be discussed for further recommendations.	

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	stand or cart. This deficient practice could affect any staff in the 400 hall oxygen storage room. Findings include: Based on an observation with the Director of Maintenance on 05/24/12 at 12:46 p.m., there was an unsupported cylinder of compressed oxygen in the 400 hall oxygen storage room. Based on an interview with the Director of Maintenance at the time of observation, the oxygen cylinder contained fifteen cubic feet when full. 3.1-19(b)			

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was exercised under load at least 30 minutes monthly. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer at least monthly, for a minimum of 30 minutes. This deficient practice could affect all occupants. Findings include:	K0144	1) Corrective action for alleged deficient practice: The generator was adjusted to run monthly for 30 minutes under load and 10 miutes for cool down.2) Identification of others with potential to be affected: No residents were negatively affected by alleged deficient practice.3) Systematic Change: The system change was to adjust the run time under load to ensure that the generator functions according to life safety code guidelines.4) Monitoring of system: The maintenance director will review the time meter after generator has ran under load monthly to ensure that requirements are met. The administrator will review generator log monthly during CQI to identify any issues or non-compliance for 3 months and then quarterly thereafter until we have 2 quarters with no issues with non-compliance	05/25/2012

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	Based on record review of the untitled generator log with the Director of Maintenance on 05/24/12 at 11:30 a.m., the generator was exercised under load twenty minutes then had a ten minute cool down period. Based on an interview with the Director of Maintenance at the time of record review, he confirmed the generator was operated under load for twenty minutes, then it had a ten minute cool down time. 3.1-19(b)			

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K0147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 receptacles in the 400 hall medication room was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect any staff with access to the 400 hall medication room. Findings include:	K0147	1) Corrective action for alleged deficient practice: The ground fault circuit interrupter in 400 hall medication room was replaced.2) Identification of others who have potential to be affected: All sink areas were inspected to ensure that ground fault circut interrupters are within compliance of Life Safety Code. No other areas were identified.3) Systematic Change: Monthly test of all GFCI breakers and receptors will be completed by the maintenance director to ensure operation awith compliance of the life safety code.4)Monitoring of system: The administrator will review monthly audit records for compliance during the CQI meetings for 3 months and quarterly for 2 quarters or until the facility has documented 2 quarters of compliance.	05/25/2012

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY NURSING AND REHABILITATION CENTER	2827 NORTHGATE BLVD FORT WAYNE, IN 46835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on an observation with the Director of Maintenance on 05/24/12 at 12:30 p.m., there was an electrical receptacle on the wall within two feet of a sink in the medication room. The receptacle was not a GFCI receptacle. When the Director of Maintenance was asked if there was a GFCI breaker for this receptacle in the breaker box, he said there was not. 3.1-19(b)			